KENTUCKY DEPARTMENT OF WORKERS' CLAIMS
Frankfort, Kentucky 40601

REQUEST FOR INFORMATION
(To Accompany Form SI-02)

It is the responsibility of each self-insured employer to provide the Department of Workers' Claims with accurate, up-to-date information for our records. The Self Insurance Branch is to be informed of <u>any change</u> in the administration of the self-insured company's Workers' compensation program, including contact names and telephone numbers, third party administrators, and self-administered policies.

To the Department of Workers' Claims: _____, 20___.

1**) Name of Applicant:** _____

Federal Employer ID Number: _____

Address: _____
(Number) (Street) (City or Town)

_____
(State) (Zip + 4) (County)

Contact Person: _____

Phone Number: _____ **Fax Number:** _____

E-mail Address:_____

<u>2) ADMINISTRATION OF SELF-INSURANCE PROGRAM</u>

A) Is the administration of the self-insurance program handled in-house? _____Yes _____No

B) If the administration of the self-insurance program is handled by any Third Party Administrator, please provide the following information:

Company Name _____

Address _____

Contact Name _____

Phone Number _____ Fax Number _____

E-mail Address _____

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3) CLAIMS ADMINISTRATION

A) Is the administration of claims handled in-house?
_____Yes _____No

B) If the administration of claims is handled by any Third Party Administrator, please provide the following information:

Company Name _____

Address _____

Contact Name _____

Phone Number _____ Fax Number _____

E-mail Address _____

4) SUBSIDIARY/DIVISION/LOCATION INFORMATION

Please list all **entities (including all subsidiaries and divisions)** doing business within the Commonwealth of Kentucky that are to be included under your self-insurance program. Divisions should be listed under the appropriate corporate name. The corresponding address of each work location is to be included.

Please Note:

1- A **Self-Insurers Guarantee Agreement** must be on file for each subsidiary. If there is **no** Guarantee Agreement on file, the subsidiary **will not** be listed as being covered in the self-insurance program.

2- It is the **responsibility of the self-insured company to notify the Self-Insurance Branch of any and all changes** involving the subsidiaries, divisions, and work locations located within the Commonwealth of Kentucky. Written notification should be forwarded to The Department of Workers' Claims Self-Insurance Branch at the earliest opportunity indicating any locations to be added to or deleted from the self-insurance program, and any changes in name or address of work locations.

SUBSIDIARY: _____

(Name) (FEIN Number)

_____

(Address)

Division: 1)_____

(Name and Address)

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Locations: A)_____

(Name and Address)

Division: 2)_____

(Name and Address)

Locations: A)_____

(Name and Address)

If additional pages are required to properly list all entities to be included, please utilize the same format used above.

Please ensure that this Request for Information page is completed in its entirety in order for your Self-Insurance Certification process to be completed.

It is the Policy of the Department of Workers' Claims Self-Insurance Branch for this Information to be provided **each year,** as part of the re-certification process. This information is essential to maintain complete and accurate records on all of the Self-Insured Companies.

Please Note: The self-insured company is responsible for notifying the Department of Workers' Claims Self-Insurance Branch, in writing, of **any changes** to this information which occur at **any time** during the approved period of self-insurance.